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Clinical Lecture.

EPIPHORA OR WATERY EYE.

By PROF. L. WEBSTER FOX.

GENTLEMEN:

THE patients I bring before you to-day show conditions which you will frequently see in every day practice; and; to successfully treat them, should call forth not only considerable surgical skill on your part, in trying to alleviate their sufferings, but, when you have accomplished it, you will have gained their very great gratitude.

This woman has suffered from an accumulation of tears on the anterior part of her left eye for several years, and she is under the necessity of frequently wiping them away, otherwise her vision would become blurred on account of the morbid refraction which they produce in the rays of light that enter the pupil.

The least exposure to cold or draughts of air causes the excessive secretions to overflow the edges of the eye-lids and

*An abstract of a Clinical Lecture delivered at the Medico-Chirurgical Hospital.

produce an eczematous eruption on the cheek. The seat of the trouble may exist anywhere along the track of the canal, from the opening of the puncta lachrymalia to its opening in the nostril. As you are aware, the lachrymal gland which secretes the tears is situated in the orbit to the upper and outer quadrant. This gland, in a normal condition, secretes sufficient fluid to lubricate the eye-ball, to aid in keeping the cornea nourished and also aiding in washing away extraneous matter which otherwise would find lodgment on the transparent cornea and cause, first, dimness of vision, second, permanent loss of sight.

When the epiphora is not induced by an affection of the mind, any inflammation of the conjunctiva will be sure to superinduce a hypersecretion of tears. This inflammation may affect the puncta, and then we should simply have an epiphora due to closing of the opening of the canal by excitation. In this patient such a condition does not exist to any marked extent, and I am inclined to believe that we shall find the seat of the trouble beyond this point, and deeper along the track of the canal. I shall press

gently upon the sac and this reveals that pus is escaping into the palpebral fissure. This aids us in locating the seat of the trouble, although we are not certain but that the lesion may be at a point further down the tract. I am inclined to think that this is the condition here, for had the mouth of the sac been open, pressure from above would have caused the secretion to have been forced along and emptied into the nasal cavity. Were this inflammation permitted to go on we should have but one ending, the pus would accumulate in the sac, acute inflammation take place, the tissues surrounding the sac break down and fistula would be the result, opening outwardly; again, the pus burrowing along the nasal bone, finding its way into the nostril, leaving necrosed bone in its track, causing a most deplorable condition to the patient.

In many cases we do not find any complications, other than simple stricture of the mouth of the sac. In such cases we do not find the existence of pus but simply an over-flow of tears. Such a case was brought to my notice by Dr. Andreas of South Bethlehem, and another patient where the puncta was too small was referred to me by Dr. Gibb of this city.

The second patient is a man who has had lachrymal trouble dating back for at least ten years, commencing as he tells us by a simple overflow of tears and eventually ending in a chronic discharge of pus from both eyes. This case forcibly illustrates the failure of treatment at the hands of the best surgical skill. For ten years he has had all kinds of treatment excepting one, the insertion of the silver style, but of this I shall speak later. You must bear in mind that it is not always a lesion at the orbital end of the canal that you have to treat, but it may be obstruction at the nasal end of the canal that prevents the escape of tears. I may say in passing that a careful surgeon has the nasal cavities examined in all intractable cases. You have had many opportunities of seeing these cases and others in the various stages of the disease, and during the winter many similar conditions will be shown here. As regards treatment, when you have epiphora due to conjunctivitis, mild astringent lotions such as we use daily at our clinic will answer very well. For those of you who have not at hand

the prescription I shall repeat it:

R Acidi borici.
Sodii chloridi, . . aa . . . gr. xx.
Aq. camph.
Aq. destil . . . aa ℥ii.

When there is a narrowing of the puncta you dilate it with a fine pointed probe such as I show you. When, however, you have conditions such as you find in these two patients, you proceed to more radical measures, slit up the canal with a Weber's knife and follow this by passing a good sized probe through the canal, and then insert a silver style. The slitting of the canal and passing the knife down into the canal is apparently a simple operation, but still one not free from danger; false passages are easily made, or the knife may break by wedging it into the bony canal. Great care must be exercised, especially when you have necrosis of the bone, such as I find in this second patient.

As regards treatment in general, astringent washes, as I remarked previously, do good in certain conditions. Syringing as first recommended by Anel in 1712 and by Blizard in 1780, has had advocates from that date to this, but even this method counts as many failures as successes. The modern day treatment as followed by the French and German ophthalmic surgeons believe in fine probes which of course do not dilate the canal to any extent, many of the English surgeons, on the other hand, dilate the canal to its fullest calibre. In this country ophthalmic surgeons are divided as to the calibre of the probe used. My own experience carries me into using probes of the larger sizes, followed immediately by inserting a silver style such as I show you. The detail of the operation is carried out as you observe. I stand behind the patient, supporting his head against my body; as the operation is being performed upon the left eye, I press the thumb of my right hand over the cheek bone and just along the lower edge of the eyelid, which, by this action is drawn slightly down and out. The bulbous point of the Weber's knife is inserted into the puncta, the handle of the knife is then dropped below the horizontal plane of the eyelid, the knife with the cutting edge of the blade inclined towards the eye ball, is pushed towards the

nose; when the point of the knife has touched the nasal bone, as I have done here, it is raised to the vertical position, the cutting edge of the blade rotated forward and pushed forcibly yet gently into the canal, burying the blade well up to the handle. As you notice I have done so without difficulty and without much pain to the patient I withdraw the knife and by gentle pressure for a few minutes stop the slight bleeding. A silver probe of large size is now inserted which passes well down into the canal; this is allowed to remain for several minutes and I follow this by placing this silver style into permanent position. This tube is allowed to remain in the canal for several days, when it will be removed, cleansed, and returned to its place. This may be repeated at intervals of several days, until the secretions have disappeared and a free opening obtained.

With this second patient I anticipate a much more difficult operation. This man has had many operations performed, yet in spite of the good work a stricture has formed at the mouth of the sac. In such cases it is worse than useless to try to pass a Weber's knife. We must try to make the opening with a different knife, and for this purpose nothing approaches a Stilling blade such as I show you. The same action of inserting and passing the knife downwards is made as in the prior operation. This incision is followed by inserting the large sized probe and style. A very simple method of proving whether the canal is open is by having the patient shut his lips and pressing his nostrils with his thumb and fingers and then trying to force the air through the lachrymal canal, and I am going to ask the patient to try the experiment. You notice that we have succeeded. The after treatment is simply applying absorbent cotton, saturated with boracic lotion, to which a little *vinum opii* has been added, about two drams to a four ounce mixture. There is one point that I must call your attention to before we dismiss these cases, and that is that great care must be used in keeping the slit from the puncta to the opening into the sac free. This is easily done by running a blunt pointed probe along this track daily for two or three days.

Original Articles.

MYDRIATICS IN EYE AFFECTIONS.

By FRANK TRESTER SMITH, A.M., M.D.

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IT is of importance, to all who prescribe even for the simplest affection of the eye, to understand the indications and contra-indications for the use of mydriatics, for the neglect of these, in proper cases, or their use in improper cases, may result in the destruction of the eye.

I desire to lay down the following general principles for the guidance of those who are not familiar with the treatment of eye diseases.

Mydriatics are indicated in the following conditions:

1st. In all inflammations of the eye except conjunctivitis. Even here they are not contra indicated, and their use is advocated in purulent forms of conjunctivitis on account of the liability of secondary ulceration of the cornea. In trachoma some advocate their use to prevent the development of an insidious iritis.

When there is a doubt of the diagnosis, and a congested eyeball, atropin should be prescribed.

2nd. In perforations of the cornea near the center whether these be produced by ulceration or traumatism. By dilating the pupil the iris is drawn from the site of the injury where it would otherwise become adherent (anterior synechia). For the same reason in perforations near the periphery of the cornea we desire to contract the pupil and myotics are indicated.

3d. In examinations of the interior of the eye.

This will enable us to detect readily adhesions between the iris and the lens (posterior synechia). Opacities in the lens are more readily seen and the condition of the vitreous more readily observed.

4th. In testing for errors of refraction.

These cases are for the specialist and demand no further notice in an article intended for the general practitioner.

5th. The convergent strabismus.

As this condition is caused by hypermetropia, for the correction of which the patient contracts the ciliary muscle, and this contraction is accompanied with a tendency of the internal recti muscles to contract, it would seem that mydriatics which paralyze the ciliary muscles would correct the squint. However their use for this condition is of very limited application. They are sometimes used for this purpose in children who are too young to use glasses.

The above are the main indications for the use of these remedies, the most important of which is the first.

The main contra-indication for their use, and one of vital importance and which should always be kept in mind, is a tendency to glaucoma.

This is indicated by an increased tension (hardness) of the eyeball. It should be looked for in all patients over forty years of age. Glaucoma is rare at an earlier age. If the pupil were dilated in a case of this kind it would probably bring on an attack of glaucoma which might destroy the eye if not promptly and properly treated.

A second contraindication is a perforation of the cornea near its periphery. Here however if iritis be present they should be used.

Dryness of the throat, flushing of the face are sometimes produced by small doses but do not contraindicate the continuance of these remedies in smaller doses. These symptoms can be lessened by holding the head to one side so that the drops will flow toward the temple and by compressing the lachrymal sac with the finger.

Mental hallucinations rarely produced by ordinary doses of atropin call for the temporary withdrawal of the remedy and its use in smaller doses.

Death from an overdose has never been reported so far as I know.

Sulphate of atropin is the mydriatic most available for general use. (gr. v. f $\frac{3}{4}$ j). The same strength should be used for children, as weaker solutions sometimes fail. If it is desired simply to examine the interior of the eye the strength may be reduced to gr. $\frac{1}{4}$ to f $\frac{3}{4}$ i., but for this purpose cocain is more readily adapted. This should not be used in the eye stronger than gr. iv to f $\frac{3}{4}$ j.

Cocain is sometimes combined advantageously with other mydriatics and is said to promote their absorption. The combination with homatropin is valuable for simply dilating the pupil or for testing the refraction, the advantage of this combination over atropin is that the effect is not as lasting. In the former case the pupil will be reduced to its normal size and the ciliary muscle will have recovered in twenty-four hours, while in the latter it generally takes two weeks.

It is not necessary to use a myotic to overcome the effect of the mydriatic for the eye will recover about as quickly spontaneously.

TEMPORARY BLINDNESS.

By J. A. TENNEY, M. D.

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HYSTERICAL blindness is not so very uncommon; but in the cases to be described, there was no evidence of a neurotic condition.

A school girl, seventeen years old, suddenly found herself nearly blind in the right eye. She could read 20 cc. There was no history of menstrual disturbance, or of taking cold. When it was examined with the ophthalmoscope, the media were found to be clear, showing the absence of hemorrhage. There was a slight blurring of the optic disc on the nasal side, and the retinal veins appeared to be slightly congested.

Upon the supposition that there might be edema of the nerve sheath on that side, iodide of potassium was prescribed in ten grain doses, three times a day. In two weeks she could see 20.c and in another week 20.lxx. At this time, strychnine was substituted for the iodide in doses of one-fortieth of a grain. In about three weeks after she commenced to take the strychnine, she had normal vision, and has retained it to the time of writing:—an interval of about a month.

Another school girl of the same age, received an injury to the right eye of a peculiar kind. She was riding by the rear window of an electric car, when the motor-man suddenly reversed the motor, to avoid running over a man. Another car struck the rear of this one, at full speed, shattering the window next to the

young lady and covering her face and clothing with a shower of broken glass. Her friends said she paid little attention to the accident. Two weeks afterward she complained of trouble in the right eye, and was taken to an oculist. He found a number of pieces of glass in the conjunctival sac. After she returned home, her family physician removed about a dozen pieces more. In about two weeks more she was seen by the writer who removed six pieces, from the size of the end of a small needle to that of a pin's head or longer. The sac was explored as thoroughly as possible, and wiped out with cotton on a probe under cocaine. After this her physician removed a number of pieces making twenty-six in all.

About two months after receiving the injury, she became nearly blind in that eye. The ophthalmoscope revealed nothing, except some congestion in the retinal veins. Her vision was about 20 cc. Atropine sulphate in two grain solution was instilled into the eye three times a day, which was the only treatment. The eye gradually grew better, and in about two weeks normal vision was restored.

Von Graefe, Schirmer, Leber, Samelsohn and others have noted cases of transient blindness following long-continued blepharospasm; but none of them ever attempted to account for the condition. There was never any blepharospasm in either of these cases.

The most unique feature in this latter case was the length of time the glass remained in the eye without producing any irritation. It was two weeks after the injury before the presence of anything in the eye was suspected. The lower lid remains congested, showing the presence of powdered glass; and the eye troubles her so that she cannot go to school—ten months after the injury was received.

2 COMMONWEALTH AVE.

What should a man desire to leave?
 A flawless work, a noble life;
 Some music harmonized from strife;
 Some finished thing—ere the slack hands
 all eke
 Drop—should be his to leave.
 Or, in life's homeliest, meanest spot,
 With temperate step from year to year
 To move within his little sphere,
 Leaving a pure name to be known or not;
 This is a true man's lot —Anon.

STUDY OF THE RELATION OF GENERAL DISEASE TO THE DEVELOPMENT OF CATARACT.*

By EDWARD JACKSON, A.M., M.D.

Professor of Diseases of the Eye in the Philadelphia Polyclinic; Surgeon to Wills Eye Hospital.

THE possible causes of cataract may be considered under three heads, namely: Senile degeneration; disease of the eye itself; and general disease impairing the nutrition of the crystalline lens by some influence exerted through the blood or through the nervous system.

The influence of senile change is obviously indicated by the occurrence of cataract chiefly after middle life. That such an influence exists, and is powerful, probably no one questions; but the view that it is the sole cause, or anything more than a predisposing cause in a majority of cases, seems to be negated by the clinical history of cataract. The changes of age, those which result from the lapse of time and the purely physiological use of an organ under physiological conditions must be, in the main, slowly and steadily progressive; at least, if they were more evident at some times than others, they would never become entirely stationary or in any case retrogressive.

The one fact, however, in the clinical history of so called senile cataract that seems firmly established by the studies that have heretofore been made of it, is that in the majority of cases the condition is not steadily progressive, but is marked by periods of rapid increase and periods of little or no change, or even in certain conditions, by periods of diminution of opacity.

I well remember a case occurring some years ago in the service of Dr. Harlan at Wills Eye Hospital, where we were inclined to think from the appearance of the opacity that it was likely to be rapidly progressive, the patient received the opinion with perfect composure and apparent indifference, the cause of which became evident when she informed us that she had been told the same thing six years before, and that there had been no perceptible change in her vision during that interval.

*Paper read before the Philadelphia County Medical Society, November 1893.

In a classical case reported in the *Royal London Ophthalmic Hospital Reports*, 1866, Bowman had seen the patient eighteen years before, and had made a drawing of the opacity, which substantially represented its appearance after this long interval.

In a large proportion of the cases of advanced cataract that come to us, the history, as obtained from the patient shows one or more periods of a rapid increase of the cloud over the sight, with other periods in which there was little or no change. In my experience it is quite the exception to find that the difficulty has increased steadily and continuously after a period of months or years. From this observation the obvious deduction appears to be that although senility may be a predisposing cause, the efficient determining cause of cataract must be of quite a different character, at least for the great majority of cases.

Of the importance of local pathological conditions within the eye-ball, particularly those of the nutritive coat, the choroid, the importance of which has been strongly urged by Dr. S. D. Risley, I do not now propose to speak. Their importance is certainly very great, but it seems to me clear that general conditions of nutrition are also of importance in this connection. It may be claimed that general conditions act by their influence on the choroid. But even admitting this, such influence often does not become evident by any changes that can be detected in that membrane, but only by the resulting altered nutrition of the lens; and the changes in the choroid, though they may exist, being secondary to the general departure from health, the practical thing to do is to fix our attention and address our remedies to that.

The literature of cataract as carefully reviewed by Dr. de Schweinitz shows a large number of attempts to connect the occurrence of lens opacity with particular general diseases, but with conclusions based upon very insufficient data. For instance, one writer reports a series of cases of cataract in which heart disease was present, and upon the frequency of such a concurrence attempts to establish a connection. So many are the factors to be considered that probably no statistics of concurrence possible, up to the

present time, or likely to be obtainable in the near future, would furnish a substantial basis for any valuable conclusion in this direction.

Again, very many reported cases, and this applies particularly to the striking ones that might be regarded as of great value, are vitiated by probable inaccuracy of diagnosis.

The difficulty of avoiding errors of this sort may be illustrated by a case reported by Dr. Ruschenberger, of this city, in the *American Journal of the Medical Sciences* for January, 1846. In this case, which was one of acute pneumonia, he noted that "a cataract formed in the right eye within thirty-six hours, and without any appearance of local inflammation. It was ashy white, and vision totally extinct." The case, however, proved fatal. At the autopsy it was discovered that "what was supposed to be a cataract proved an effusion of lymph within the margin of the pupil slightly adherent to the iris. This lymph formed a disk covering the anterior face of the lens, which was transparent."

Indeed, so imperfect has been the observation of cases, and the sifting of evidence bearing upon this subject, that with regard to the share of particular diseases in the causation of cataract, it is only perhaps with reference to diabetes and ergotism that the testimony can be regarded as sufficient to establish a connection.

Of course, so many inconclusive attempts to establish such a connection between cataract and disease are of value as negative evidence that no such connection exists. They do not, however, militate against the view, that certain vices of general nutrition which may arise in many specific diseases are an important factor in the production of cataract.

Organic heart disease, gout and arterial sclerosis, as distinct diseases, may have little connection with the cataract, yet in their course there may arise the physical conditions which will in particular patients determine the opacification of the lens. To determine whether that is or is not the case will only be possible by the careful and prolonged study of individual cases, the opportunity

for which is rarely accorded to the ophthalmic surgeon.

Several years ago, while in general practice, I had an opportunity of watching a case of mitral disease, during several months of cardiac insufficiency, along with serious gastric disturbances. During this period there was rather rapid impairment of vision through the development of lens opacity, presenting the ordinary clinical characters of cortical senile cataract. Finally, compensatory hypertrophy re-establishing the balance of the circulation, the digestive disorders were relieved and a better state of health was brought about. Vision slightly improved, and for two years the cataract remained quite stationary. After that, I am informed, her impairment of vision was very slightly progressive for several years. But, prior to her death, as her general condition became impaired the cataract again grew rapidly worse.

Though cases of this kind may occur frequently, such a patient consulting one or more ophthalmic surgeons in the period of comparative health, they would be quite unable to establish any connection between the lens opacity and the general disease. Again, the medical practitioner who did not employ the ophthalmoscope, or who was not sufficiently familiar with its use to exclude changes in the choroid or vitreous from any share in the progressive impairment of vision, would be quite unable to give convincing evidence upon the subject.

It would seem that here, as in so many other cases, scientific knowledge is only to be advanced by the working together of the specialist and the general practitioner. It might be supposed that this could be accomplished in the general hospitals that have upon their staffs skilled ophthalmologists. But such a study to be of any considerable value must extend over a long period—many months or years; and hospital patients are proverbially inconstant, so that to follow them for the necessary length of time is generally quite impossible. The conditions of private practice, where the family physician remains the trusted medical adviser for years, are those most favorable to such a study, and under its conditions it ought to be more frequently undertaken.

This is especially the case, since the good of the patient urgently demands exact and skillful treatment in all cases of commencing senile cataract. If we are to-day able to do less than we desire to influence the general conditions, we have some positive knowledge and ability to cope with the local conditions which attend or cause the development of cataract, and the interest of the patient demands the application of our knowledge in every case. Nor is the consultation of the ophthalmologist only justified when a commencing cataract is feared. There is no condition leading to impairment of vision in the course of acute or chronic general disease in persons over fifty years of age that does not demand prompt and accurate diagnosis and appropriate modification of the management of the case.

In early life we do have failure of accommodation, and perhaps some other conditions leading temporarily to impaired vision during or after acute diseases, which may go on to recovery without medical interference; but in persons past fifty years this does not occur; and, whether the impairment of vision be from cataract or from some other cause, there is equal need of a full understanding of the case.

Probably the mere calling of certain forms of cataract "senile" is partly responsible for their neglect. Cataract is not due to age in the sense that arsenical poisoning is due to arsenic. It ought to be clearly understood that cataract is senile in the same sense as are fibroid kidney, or arterial atheroma, and is quite as worthy of careful diagnosis and intelligent treatment. The interests of the patient demand his professional supervision; the benefit he may derive from it is as definite and unmistakable as in other diseases. And this supervision should include general as well as ocular conditions, and when it does we begin to accumulate data upon which the medical treatment of cataract will be a rational procedure.

What the general conditions are that specially favor the formation of cataract in the present condition of our ignorance it is scarcely worth while to speculate. Perhaps the most plausible hypothesis is the one urged by the late Dr. Isaac Hays,

that the lens opacity is due to a deficiency of water. This was offered as the explanation of diabetic cataract, and that produced experimentally by injections of sugar and various salts beneath the skin of the lower animals. It is also favored by the evident shrinking of the lens when cataract is produced by feeding the animal with naphthalin and the subsequent clearing of such a lens when placed in water.

An hypothesis more nearly in accord with the present views of general pathology, and one probably worth bearing in mind, would be that of the formation and circulation within the body of substances which, reaching the lens by the normal course of the nutritive fluids, act upon it unfavorably.

Briefly, the points which I desire to emphasize by this paper are :

In general, senile change does not produce cataract, but predisposes to it.

The efficient determining causes of cataract are both ocular and general.

The general causes of cataract are not particular diseases as diseases are usually described and classified, so much as physical conditions liable to arise in the course of various diseases.

The nature, prevention and removal of these general conditions that underlie the development of cataract offer promising fields for scientific study.

The professional supervision necessary for the making of such a study is demanded by the interests of the individual patient.

Speaking more specifically, the study of a cataract case should include the careful testing of vision at regular intervals.

The further examination of the eye to determine in how far impairment of vision is due to cataract, and in how far it is due to other causes.

The careful watching of the patient for other symptoms of impaired general health, especially for faults in the circulation, digestion and assimilative metabolism.

Particularly at the first appearance of cataract, and at seasons of its rapid increase, would such a study of the case be of importance.

THE RELATION OF DISEASE AND OF MORBID CONDITIONS OTHER THAN THOSE LOCATED IN THE EYE TO THE FORMATION OF CATARACT.*

By G. E. DE SCHWEINITZ, M. D.,

[Clinical Professor of Ophthalmology, Jefferson Medical College; Professor of Ophthalmology, Philadelphia Polyclinic, etc.]

THE etiology of cataract is by no means always clear, and, independently of the studies which pertain to the pathological anatomy of opacity of the crystalline lens, much interest resides in the causes which may originate clouding of its structure. I omit entirely reference to the influence of age, sex, occupation, heredity, diseases of the eye, and accommodative strain, each and all of which are important factors, and desire to call attention to those cases which bear some relation to nutritive disturbances, in their turn dependent upon constitutional disease, or upon more localized extra-ocular conditions.

For convenience of study, I have arranged the cases in which disease bears some relation to the formation of cataract into :

I. Idiopathic Fevers and Allied Diseases. (a) Typhus and Typhoid Fever.

—It is a matter of common observation that the clinical history of cataract formation will not infrequently reveal that the patient refers marked failure of sight to some decided febrile disturbance, but it is difficult to prove that this has positively been the cause of the depreciation in vision.

A little more to the point, but none the less of indifferent value, are the observations by Trelat¹ on cataracts following typhoid fever, in which he describes double, semi-soft cataracts in a young girl which began to develop during convalescence from typhoid fever Fontan² reports three cases of post-typhoid cataract (cataracta punctata) which he believes were the result of mechanical obstruction of the circulation.

(b) The Exanthemata.—As the malnutrition of typhus and typhoid fever may perhaps be responsible for lenticular

*Abstract of paper read before the Philadelphia County Medical Society, November, 1893.

¹ Gaz. des. Hopitaux, 1879, p. 417.

² Rec. d'Ophth., 3 serie, 9, 1887.

opacities, likewise this is true of the various exanthemata, quite independently of the fact that these diseases may cause local inflammatory conditions which would determine the opacification.

(c) *Whooping-cough*.—For the most part, the reports concerning the relation between whooping-cough and cataract formation are vague, as, for example, such indefinite cases as were reported in pre-ophthalmoscopic days by Wright,¹ who records the case of a baby, aged eighteen months which was able to see for twelve months, then had whooping-cough, and afterward cataract.

(d) *Malaria*.—Inasmuch as severe malarial fever of any type may be accompanied by lesions in the vitreous and the choroid—for example, hemorrhage, which after absorption leaves membranous opacities and areas of atrophic choroiditis—there is no reason why cataract should not form. A more direct connection than this seems doubtful.

(e) *Epidemic Influenza*.—During the prevalence of epidemic influenza, or la grippe, so fresh in the minds of all of us, a large amount of attention was directed to the ocular lesions, and a great variety of affections, inflammatory and otherwise, which occurred in the eyes of the sufferers were attributed, and no doubt in many instances rightly, to the influence of this extraordinary disease. Therefore, it is not unlikely that the disease, producing such serious inflammatory lesions, may be followed by cataract.

II. Constitutional Diseases. (a) *Gout*.—Zychon² contributes an article upon the influence of gout in ophthalmic disorders.

(b) *Rachitis*.—Punctate cataract sometimes occurs in connection with rachitis, and Nicati³ brings the total cataracts (not congenital) which are sometimes found in children into etiological relationship with rachitis.

A history of convulsions is common, and the dental defects which are present in the form of lines, furrows, or terraces, running transversely across the incisors

or canines, are considered by Hutchinson to be due to the mercury which in all probability was given for the convulsions, which in their turn caused the cataract. Therefore, the cause does not reside in rachitis itself, but in the frequent, severe, and long-continued convulsions to which its subjects are liable. Moreover the cause does not pertain alone to the general convulsions, but to the disturbance of the lens brought about by the severe ciliary muscle cramp which is said to be present in all universal convulsive affections. Such a result can obtain, however, only in the earlier years of life, while the process of development in the lens is still an active one.

(c) *Constitutional Syphilis*.—This disease, like other affections which are prone to attack the uveal tract, is not infrequently followed by secondary cataract as the result of disturbances in the nutritive processes of the eye. Some authors, however, have described so-called true syphilitic cataract, dividing these cases into two classes: 1. Capsular cataracts which are associated with iritis, etc.; 2. Lenticular or true cataracts, which are rare, and directly due to syphilis. They are soft and appear in the second period of this disease, presumably without the intervention of inflammatory processes in the ocular coats.

(d) *Diabetes*.—The usual answer to the question "What is the most frequent ocular lesion in diabetes," is "cataract." We have in evidence the occasional spontaneous disappearance of diabetic cataract, in some instances corresponding with a diminution of the amount of sugar in the urine.

Touching the pathology of this affection, and throwing some light upon the relationship between the disorders Deutschmann¹ examined four cases of diabetic cataract, finding proliferation of the layer of pigment cells on the posterior surface of the iris, a condition which had previously been described by Becker. In the lens were vesicular cells (blasenzellen) and all the changes from normal nuclei to complete nuclear disintegration. Deutschmann concludes that the opacity in the lens is due to a necrotic tendency of the epi-

¹ Western Med. and Phys. Journ., Cincinnati, 1827-28, 1, 428-431.

² "De la Goutte oculaire," Rec. d' Ophth., 1885.

³ "Cataractes et Lésions dentaires des Rachitiques," Abstract, Jahresbericht f. Ophthalmologie, 1879, vol. x, p. 341.

¹ Graefe's Archiv. xxxiii, Abth. 2, p. 229.

thelial structures, just as the same tendency is shown by all epithelial tissues in this disease. Referring to these researches, and others like them, Knies points out that in certain cases the iris is more or less changed—sometimes atrophic, sometimes slightly inflamed—in other words, uveal tract inflammations may be present in diabetes. The development of cataract, then, belongs not so much to the presence of sugar, but is an intoxication symptom—a species of auto-infection.

III. Local Diseases. (a) *Diseases of the Heart and Atheroma of the Vessels.*—One of the earliest communications on this subject is a report, by Furneaux Jordan on the relation of cataract to heart disease. Nineteen cases are reported: 2 under twenty years of age, 7 between forty and fifty, 5 between sixty and seventy, and 5 past the seventieth year. These patients suffered from various forms of organic cardiac lesion and had cataract.

A more modern view of a somewhat analogous relationship is the theory of Michel, that circulatory disturbances, and particularly atheroma of the carotid, may be responsible for the formation of cataract. Michel came to the conclusion that opacity in the lens substance was a symptom of a local or general disturbance, and that so-called senile cataract depended upon sclerotic changes in the walls of the carotid.

Other observations on the same subject have been brought forward.

(b) *Nephritis.*—Naturally, the various types of so called Bright's disease, and the widespread lesions which they may produce throughout the body, have been brought into connection with the formation of cataract.

While it is of the utmost importance, both in determining the prognosis of the affection and also that of operative interference, to examine the urine of every cataract patient, and while albumin and sometimes tube casts may be found, no causal relation has been positively established between nephritis and cataract.

(c) *Nervous Diseases.*—We have already determined that zonular cataract, which has been found in association with

rachitis, is more likely due to convulsions, or to local cramp in the ciliary muscle, than to the disease itself. In like manner, those examples which have been found in connection with other complaints, more particularly belonging to lesions of the nervous system, for example, epilepsy, are explainable by the presence of convulsive disturbances.

Meningitis has been made responsible for the formation of cataract in young individuals.

(d) *Diseases of the Skin.*—Mooren, quoted by Norris, asserts that chronic skin eruptions may favor the development of cataract by causing creeping inflammatory processes within the eye, and Forster believes that it is not impossible that chronic skin affections may favor to the development of a depraved nutrition, which in its turn produces cataract by alterations in the nutrition of the lens.

IV. Toxæmias.—Although, perhaps, not belonging strictly to the list which I have discussed, it would seem proper to refer to one or two forms of cataract which have developed, if not under the influence of, at least in association with, the action of certain drugs. Foremost among these are the observations which relate to the development of opacity of the crystalline lens in connection with ergotism, or, as is often called, the formation of raphanic cataract.

Numerous papers have appeared upon this subject, to which reference is unnecessary, except to say that, as, for example, in those cases reported by Tep-ljaschin,¹ 27 in number, occurring during an epidemic of ergotism, and for the most part under thirty years of age, the development of the cataract was ascribed rather to convulsive disorder than to any distinct action of the poison itself. Hence it seems proven that the lenticular opacity results from the violent general convulsions, and not directly from the ergot.

Among other toxic agents that are known to cause cataract is naphthalin. Experimentally, cataract has been produced with this drug by feeding it to rabbits, but it should be mentioned that, in addition to the lenticular opacity, there are general disturbances as well as changes in the retina and vitreous.

¹ British and Foreign Medico-Chirurgical Review, 1857, vol. xix. p. 484.

¹ St. Petersburg, med. Wochenschr., 1880, No. 3.

Other drugs and toxic agents have in a vague way been suggested as a possible cause of opacities in the crystalline lens, but it is likely that these relationships have existed in the minds of the patients rather than in reality, and before they can be accepted, direct experimentation, especially upon the lower animals, will be required.

The evident influence of eye-strain and asthenopia in its widest sense, together with the changes which this produces in the ocular coats, particularly the choroid, referred to by Galezowski, insisted upon by Schoen and more recently elaborated by Risley, on the formation of cataract is well established. Possibly constitutional diseases permit this influence to be more strongly felt, and thus indirectly aid in the development of lenticular opacities, or, perhaps, a more direct influence can be established. Be this as it may, further critical evidence is needed.

CATARACT.

THE ancients knew the operation for cataract, which they performed by depressing the opaque lens into the vitreous by means of a needle. Nevertheless, they had an erroneous conception of the nature of the disease, in that they located the opacity not in but in front of the lens. This latter body, bright as crystal, the most obvious thing when the eyeball is opened, was considered by the ancients to be the true seat of vision, the percipient organ, such as now we know retina to be. According to this view the loss of the lens would necessarily entail complete blindness; but since the ancients knew that in the operation for cataract the opacity is removed from the pupil, and nevertheless the sight is not lost, but on the contrary, is restored, they could not consistently regard the opacity as located in the lens. They thought the opacity which they depressed into the vitreous was situated in front of the lens. They believed that it originated from the pouring out of an opaque liquid between the iris and lens. * * * Since it was imagined that the opaque liquid fell down from above in front of the lens, the name cataracta (cataract), which still is usually employed, came into use in the middle ages.

—Fuchs.

Lecture.

THE PHILOSOPHY OF MAN.*

By JAMES E. GARRETSON, M. D., D. D. S.

(Continued from last number.)

HAVING gained the understanding that neither Common sense nor Educated sense are of relation with aught save what is objectively phenomenal, a question of largest pertinence is as to means of knowing apart from these senses. Are there things to know with which these means are incapable of dealing save inductively? With an Existence called God, for example, or with things which are to show themselves as the spiritual world, these things being one with imaginations and dreams and visions. On the contrary are imaginations and dreams and visions what the common idea of the day accepts them as being, namely, non-existences. Is God knowable after any other manner than by induction? Imaginations and the things of dreams and visions accepted as non-existences is a spiritual world denied by the common idea? or, is the spiritual world a something else than what philosophy knows as "the Subjective?"

We are to find with man means of apprehending what is not objectively phenomenal, otherwise we are to limit his world to Matter. Here opens of itself the subject of hypostases.

Human hypostases are one with man's means of relation with his circle, in other words one with means to ends; to walk requires legs, to respire compels lungs, to think demands a brain. By hypostases is meant the components of a thing. What are the hypostases of a man? Consider at this point the uselessness of a thing that is without office. Do any of us know of the existence of such a thing? Is it then to be supposed that things found with man are exceptional to this universal law, or rather, is not the universality of the law one with conviction that all found with him are means of direction and evidences of purposes?

No Common sense man lives who de-

*Lecture before the Garretsonian Society, delivered at the Medico Chirurgical College, Nov. 28, 1893.

nies the reality of his body. He declares to seeing what he sees, of hearing what he hears, and of tasting what he tastes. It is nothing against this conviction that an Educated sense man knows that sight, hearing and taste are in percipient, that variety as to sounds is one with tympanic vibration, and that sourness or sapidity as to taste one with a gustatory nerve, in other words, eyes, tympanum, and nerve being away he who declares as to sight, hearing and taste would be without personal consciousness as to the existence of things of which he declares.

Here an aphorism that covers the ground we have gone over; a ground enveloped by the consciousness that nothing is what it seems to be.

A thing is to a sense that uses it what to the sense it seems to be.

Now to Common sense and Educated sense, the two being one as to general likeness and significance, there are fastenings called nails that hold things together when joined by them, albeit a nail resolved after one manner proves to be a piece of iron, and, before that, a nugget of ore, and, still before that, a block of rock. Resolved after another manner it is found, through exposure, resolved into red dust, which dust is the ferri oxide of the chemist, the ferruginous tonic of the apothecary, the hematin of the physiologist. Looked at closer still a nail is found to be matter, and what matter is nobody knows. So it is a truth that he who does not know what matter is does not know what a nail is. This, however, only as to noumenon; phenomenally he knows, or can know all about a nail and its uses; these, whether he handle rock, nugget, iron red dust, oxide of iron, or ferruginous tonic. Each phenomenon will be to a man exactly what the man is able to find in it. Wholly unable to say what a nail is, *per se*, the man is as wholly able to say what it is as concern and relation are with his circle and its needs; a nail to a carpenter an elixer vitæ to a physician. Are these premises to be denied or disputed, and if neither, goes not the inference that a man's world is exactly what the man is?

Here we are to anticipate. An idea to be conveyed is that it is precisely with the so-called spiritual as with the so-

called natural. An eye that sees no fringed monsters in water, or eels in vinegar, comes to see both as it advances in the line of optical development. The line of optical development is the enlargement of the sense of sight by use of means that make sight clearer. No more can people uncultivated as to the spiritual sense, see spiritual things, than can people, uncultivated as to optics see fringed monsters and vinegar eels. But, are things to be seen that have no existence? We see and use the fruit and shade of trees yet are compelled to admit these as phenomena. We fasten together the things of a house with nails, yet find a nail one with iron to-day and one with blood to-morrow; yet never do we find the nail else than is the appeal to a sense that uses it. Consider in this connection the things called inventions. Is an invention less a real thing that no model has been made? Is it, or is it not the case that idea which precedes model, is the reality, or is it model, which is assuredly simple representation, that is reality? If decision accord the true existence to the former, as approaching nearer the nature of neumenon, can it fail to be felt that unseen and seen are expressions, to say the least of it, of a common existence? Is not reality closer with the unseen than with the seen for does not the seen in the case of an invention require, in order to exist, constant renewal, while the unseen, the unmaterialized idea, remains persistent through the ages.

If it be understood how a man relates through his organic senses with the external world we are prepared to pass to his internal or spiritual world, and from this onward to his knowledge of and relation with God.

By a spiritual world is meant things not seen, heard, tasted, smelled or felt by the senses of organic life, while by knowledge of, and relation with God, is meant knowledge of the infinite independent of books and traditions.

We here go back to our aphorism "*A thing is, to the sense that uses it what to the sense it seems to be*" He who sees spirits sees spirits, and he who communes with God communes with God. If here it be insinuated that the declaration is one with assertions of the equal reality of objects and imaginations no objection is to

be made—save it might be that the higher truth gives preference to imagined things as in the case of inventions.

This is not to be assertion, however, but is to rest with analysis; and here it is that we fairly meet the "Cogito, ergo sum" of Des Cartes.

Rene Des Cartes would have no books or traditions. He would believe through knowing or not believe at all. His words were "True philosophy may, and must, for the proving of things which may alone satisfy the intelligent mind, start in a premise which, accepts nothing but what is self-proving; that alone which is self-proving is consciousness of existence. I may doubt the existence of God for the idea of God may be a superstition. I may doubt, he says, the existence of the eternal world, for this may be a phantasm. But in the act of doubting it is impossible for me to doubt that I, who am thinking, am something."

Here we face a hypostasis, or the hypostases.

What does analysis show man to be? First, as to what thinks.

Here upon this plate is a human brain, and here, upon the table by the side of the plate, is a flute. Will the flute play music for us, or will the brain discourse ideas? We have before hinted at this. Are player and discourser, not this flute or brain, or are player and discourser away from the things upon the table? Something is away. What is away when a telegraphic message remains unwired? Is it difficult to distinguish as being two, wire and operator? Is it difficult to distinguish as two, a book and its writer? I direct the attention of the class to the cadavers in the dissecting room. Are these one with the dissectors? or is it the case that something has gone out of the former that still relates with the latter? Here is the Ego of Cartesianism, *but here is not the soul.*

We are now to analyze man, and such analysis is to show him a necessarily dual and a possible tripartite being. The possible third thing is soul, which a man can live without. It is to be said of the brain before us that an Ego has gone out of it, but, with out having known its possessor, no one can say yea or nay as to its having been occupied by a soul.

(To be continued in next number.)

Note.

PHILADELPHIA ACADEMY OF SURGERY.

THE SAMUEL D. GROSS PRIZE.

The Quinquennial Prize of One Thousand Dollars under the will of the late Samuel D. Gross, M.D., will be awarded January 1, 1895.

The conditions annexed by the testator are that the prize "Shall be awarded every five years to the writer of the best original essay, not exceeding one hundred and fifty printed pages, octavo, in length, illustrative of some subject in Surgical Pathology or Surgical Practice, founded upon original investigations, the candidates for the prize to be American citizens."

It is expressly stipulated that the successful competitor, who receives the prize, shall publish his essay in book form, and that he shall deposit one copy of the work in the Samuel D. Gross Library of the Philadelphia Academy of Surgery.

The essays, which must be written by a single author in the English language, should be sent to Dr. J. Ewing Mears, 1429 Walnut St., Philadelphia, before January 1, 1895.

Each essay must be distinguished by a motto, and accompanied by a sealed envelope bearing the same motto, and containing the name and address of the writer. No envelope will be opened except that which accompanies the successful essay.

The Committee will return the unsuccessful essays if reclaimed by their respective writers, or their agents, within one year.

The Committee reserves the right to make no award if the essays submitted are not considered worthy of the prize.

PHYSICIAN (with ear to patient's chest): "There is a curious swelling over the region of the heart, sir, which must be reduced at once."

PATIENT (anxiously): "That swelling is my pocket-book, doctor. Please don't reduce it too much."—*Our Dumb Animals.*

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PHILADELPHIA, DECEMBER 9, 1893.

GOLD IN THERAPY.

WHILE gold is a drug that is as ancient as mercury, it has been comparatively recently that it has been brought to the particular notice of the profession as anything worthy of much consideration in therapeutics; Indeed, of late, it has only been associated in the minds of most of the profession as indicative of some quack patent medicine, and hence of no especial value *per se*.

Dr. A. E. Wood of Pittsburg in an excellent article on the subject, published in the *Journal of the American Medical Association*, indicates the use of the com-

bination of gold in the liquor aurii et arseni bromidi and in the liquor aurii et mercurici bromidi, the dose of each which is ten drops, representing one thirty second of a grain of gold. The therapeutic uses of these combinations of gold seem to lie in the value they exhibit as a cure for all forms of sclerosis (meaning by the term induration of any tissue or organ.)

Thus cirrhosis of the liver, interstitial nephritis, atheroma, calcareous degeneration of arteries, the circumscribed induration following embolism or blood-clot in brain tissues, senility and its train of decrepitudes, cirrhosis of lung, fibroid consumption—miliary tuberculosis, adenitis and many other similar degenerations all come under the therapy of gold especially in this sort of combination which excels the preparation of chlorid of gold and sodium.

The result of these preparations are far superior to that obtained by similar preparations, but leaving out the gold, showing that there is real value in the gold itself over and above the arsenic or mercury and bromide.

F. S. P.

SYMPHYSEOTOMY IN CONTRACTED PELVIS, AND PORROS' OPERATION FOR RUPTURE OF THE UTERUS DURING LABOR.

SYMPHYSEOTOMY says M. Eutache (*Archives de Obstetriques* No. 7, '93.) is to-day regarded as an operation which legitimately belongs to the domain of obstetric surgery. However, it should not supplant premature accouchment for extremely contracted pelvis. During labor it must be performed when the antero posterior diameters, are less than six centimeters. But, when those diameters are more than eight centimeters we should in most cases be able to deliver with the forceps or by version. Bossi advises prompt abdominal section and Porro's operation in any case of rupture of the uterus during labor. He cites a

successful case in his own practice, and argues that in the hands of any cool operator that it adds no additional risk to life and may be readily performed. (It is well that in our time we have witnessed the uncompromising condemnation of a former practice of deliberate infantile destruction in cases of contracted pelvis, and that now without any additional danger to the mother the infant's life is spared. By Porro's operation too, the only chance is given to the child, with no additional risk to the mother.)

CURATIVE INFLUENCE OF ERY- SIPELAS IN GONORRHOEA.

MR A. SCHMIDT in the *Centralblatt für Chirurgie*, No. 39, p. 401, contributes an interesting report of a case of gonorrhoea in a three year old girl. He says that intercurrent erysipelas has for centuries been known to exercise a curative action on benign and malignant tumors, diseases of the skin and typhoid.

This observation was made on a healthy child who had the *flueurs blanches*. On inquiry it was found that the little one had been isolated and that she had been infested with blenorhagia. The day following that, on which remedies had been applied erysipales developed. It quickly spread into the vulva and checked the discharge. The child now suffered no more from pain in micturition. Six days after this second disease set in an abscess formed on the leg, which gave issue to discharge rich in the streptococci. She made a good recovery. (It is most extraordinary that any sane mortal could degrade himself to attempt cohabitation with so young a child. But purulent discharge is not uncommon in young children. If we find the gonococcus does that prove infection by contact? Certainly not, for we may see a bad clap with no cocci and *vice versa*.) T. H. M.

ON THE TREATMENT OF ERY- SIPELAS.

DR. KOLAZEK, in the *Revue Generale de Chirurgie*, 18 Oct. 1893, gives his experience in a large number of cases of erysipelas, which he has treated with

remarkable results, with phenic-acid. As erysipelas is always a disease attended with danger to life under certain conditions, we give to our readers, the doctor's method.

In the incipient stage of the disease he applies a piece of thick porous paper about the size of the hand, which is first imbued and saturated with a five per cent solution of carbolic acid. Over this, to prevent rapid evaporation, is laid a piece of rubber gauze or oiled silk, which confines the volatile medicament, and at the same time excluding the air. This dressing is extended every twenty-four hours, the area of dressings increased or diminished according to circumstances.

In erysipelas of the trunk or face, it is not so efficacious as on the extremities. The principle of the treatment for local erysipelas is, that it totally confines the perspiration over the invaded territory. In this manner the gaseous toxic products of the disease are prevented from becoming diffused, and those retained will have no deleterious effects on the erysipelas.

(This method certainly has much to commend it in surgical cases, where, it may be difficult to isolate the infected patient.—TRANSLATED by T. H. M.)

Annotations.

MEDICAL FINANCES.

WHY are medical men so poor as a class? Why do they accumulate so many bad accounts? Why is their business so largely a credit business? Why do they pay their bills so slowly themselves? These are all questions that naturally present themselves in connection with medical finances and that can be answered in general with a very few words, viz.: Because doctors are poor business men, and the profession is over crowded, necessitating an immense strife for work. This is the gist of the matter boiled down to a few words. An important fact is that medical students are, as a rule, young, and have but rarely been engaged in a business career of any nature whatsoever before commencing the study of medicine, and consequently have not even a rudimentary knowledge

of business. I know that as for myself, before I commenced practicing medicine I had never written a check or made out a note, although I have struggled under many of the latter since. I did not know how to keep books, and knew nothing whatever about equities, mortgages, or business affairs of any kind. I was a complete nonentity in such matters, and this lack of preliminary business training has always been a material hindrance to me in prosecuting my profession to advantage, and has often been of considerable loss to me financially.

Another source of difficulty in this matter is the character of young people who are allowed to study medicine. A man who proposes to enter upon this serious life work should be a man who has gone through with a good preliminary mental training. And yet it is a notorious fact that such is not the case.

No, brothers in practice, the foundation is wrong, and who can wonder at a deficient superstructure.

These are some of the initial reasons why medical men are not successful business men :

First. They are usually of a stndious rather than a business turn of mind.

Second. They have had no business training before entering upon their medical studies.

Third. Their preliminary training has often been deficient.

A physician should do as nearly as possible a strictly cash business. This is easier to do than one would imagine who has always abided by the credit system. No business is more dignified than ours, and none should be paid more promptly, and yet a groveling servility about money matters has characterized our profession for years that has permitted an inborn feeling on the part of the laity that a doctor is afraid to present his bill, and that at any rate it will not be presented till long after the services are rendered and that then it can be paid when he sees fit, and repudiated entirely if deemed expedient.

I appeal to you is this not so, and are we not to blame for it ourselves? This same feeling would grow up in our minds if we saw another business carried on in the same shiftless manner as the profession we represent. Suppose for instance,

that a stranger should walk into a dry goods store, select ten yards of silk, and quietly tuck it away under his arm and attempt to walk out of the store without paying for it. What would you call such an action? Stealing! That is right, and many of our patients do this. What would you call the merchant who would composedly see this done and say nothing? A fool! That is right. That is what *we* are oftentimes.

Bills should be presented regularly whether the patient is under treatment or not. Do not you get your bills regularly whether you are still trading at a store or not? Of course you do. Then why not present yours on the same principle? I would not advise you to go into a bed-room where your patient lies dying, when this melancholy event is transpiring on the first of the month, and tell him to pay your bill before he dies. But there can be no objection to presenting a bill from month to month while the patient is under treatment, especially if he is suffering from a chronic disease. A physician's own inherent sense of delicacy and refinement will dictate to him what to do in acute sickness, but he should not allow a false sense of sentimentality to stand in the way of looking out for his own reasonable security.

A doctor will trust people longer and more foolishly than any man on earth. He will go on trusting people for years, until they leave him on account of hating him because they have owed him so much and so long. Then they will go to another physician and pay him, with little or no hesitancy. The trouble is with you, my brother. If you find a man who does not show a disposition to treat you squarely, drop him. By so doing you will perhaps induce him to pay you, or your neighbor physician, and you will certainly inspire in his mind a profound respect for yourself, and the medical profession in general.

I would respect a man who, being rich, should see fit to adopt the medical profession as a means of bestowing charitable medical services upon the suffering poor, but I would regard a man as foolish who would run his business in a loose and shiftless manner, and allow himself to be beaten from pillar to post by every worthless imposter that crossed his pathway.

Many a physician does a good business that, properly managed, would render him free from need, and yet he may be in real distress for want of money, while he endeavors to minister to the wants of a patient who could pay him if he would, but who will not make the effort.

You owe it to yourselves, to your patients, to the profession to start out from this very hour and arrange your business so that it will render you an adequate return for the work you put into it. By so doing you will dignify yourselves and the profession, and bestow a real service upon mankind in general, and yourselves in particular.—*Extracts from Dr. Frank Allport's article in Northwestern Lancet.*

BURNS OF THE EYES.

DR. D. S. REYNOLDS in a paper before the Kentucky State Medical Society, 1892, states that where burns are so extensive as to make it impossible to prevent adhesions between the lid and ball, these may be greatly modified by leaving the eye open, and daily separating the opposed abraded structures with a probe anointed with a little yellow oxide of mercury ointment.

No injury to the eye, in the nature of a burn, should be treated by a bandage and compress; yet this plan is recommended by Nettleship, Juler, Carter, Meyer, McNamara, and he believes, nearly every writer on Ophthalmic Surgery.

TREATMENT OF FIBROMATOUS TUMORS BY ELECTRICITY.

Par MM. Labadie et Reynier (Archives Générales de Médecine).

Electricity, they say, is an invaluable agent in those fibromatous tumors of the uterus, which are announced by metrorrhagias, and in which the adnexa are free from cystic or suppurative changes. They maintain that in all cases free from these complicating factors, before castration is undertaken, or any other operation, electricity should be faithfully employed.

If the patient have pelvic neurasthenia we would give the preference to faradisation because of its sedative properties.

No one can question the great value of electricity in all those cases in which we are assured that there are no malignant elements present, and there are no urgent symptoms, as uncomplicated myoma of the uterus is seldom or never *per se* fatal to life and may often after the menopause undergo retrogressive changes and disappear.

T. H. M.

Book Notes.

NEW TRUTHS IN OPHTHALMOLOGY. By G. C. Savage, M. D., Nashville, Tenn.

In the first chapter of this book, Professor Savage proves that the oblique muscles cause images to fall upon corresponding portions of the retinae, in oblique astigmatism. The ciliary muscles cannot do this, for patients do not see double images in such cases when these muscles are paralyzed; while by means of certain artifices that interfere with the action of the oblique muscles, it can be shown by objective tests, that images do fall upon different parts of the retinae, according to known optical principles.

The second chapter is devoted to exercising the oblique muscles by means of cylinders placed in certain positions before the eyes.

The fifth chapter sets forth the "Law of Projection." He claims to have discovered the principles elucidated in these three chapters. This is undoubtedly true, and the principles thus unfolded are of the greatest importance.

He claims success in relieving heterophoria by rhythmic exercising of the muscles, when the defect does not exceed 6. He explains what has been called the Horopter, but which he calls the Monoscopter. He devotes a chapter to the relationship between accommodation and convergence, tells how to draw the line between operative cases and those that may be cured by exercising, and gives a chapter to the use of mydriatics, which he strongly advocates in the examination of all young patients.

He also describes five operations, or modifications of operations, which show much ingenuity and careful observation. Not a sentence is wasted in the book. Its typography is excellent. All ocu-

lists should possess it; and many will read it through at one sitting, as did the writer of this article. It is certainly a most valuable contribution to our knowledge of the actions and defects of the ocular muscles. J. A. T.

A MANUAL OF PHYSICAL DIAGNOSIS FOR STUDENTS AND PHYSICIANS. By James Tyson, M. D., Second Edition. Published by P. Blakiston, Son & Co., Philadelphia. Price, \$1.50.

The second edition of this concise and admirable manual is revised and enlarged in such manner as to cover now fully the subject of physical diagnosis. The work abounds in useful illustrations to elucidate the text.

An "appendix" has been inserted, which, although it does not directly bear upon physical diagnosis, is most useful to the physician and student inasmuch as it dwells upon the examination of blood—the more important bacilli associated with infectious diseases, chemical examinations required for diagnosis of gastric diseases and directions for conducting an autopsy. The work is well worth the price asked.

THE IDEAL PHYSICIAN'S VISITING LIST. Published by P. Blakiston, Son & Co., Philadelphia.

The fact that this visiting list is now in its forty-third year of publication speaks for itself. Besides the blank pages for accounts with patients there is a great deal of valuable concise information on various subjects. A comparative table of metric and English system of weights and measures; a dose table of official and unofficial drugs, in both systems of weights; a list of new remedies; poisons and antidotes; disinfectants, etc., etc. The whole makes a little volume easily carried in the pocket.

Books and Pamphlets Received:

REPORT OF THE BOARD OF MANAGERS OF THE PENNSYLVANIA HOSPITAL.

PREVALENT ERRORS IN THE TREATMENT OF THE DISEASES OF WOMEN. By G. Betton Massey, M. D., Philadelphia, Pa. Reprinted from the *Therapeutic Gazette*.

THE RELATION OF THE PATELLAR TENDON-REFLEX TO SOME OF THE OCULAR REFLEXES FOUND IN GENERAL PARALYSIS OF THE INSANE. By Charles A. Oliver, A. M., M. D. Philadelphia, Pa. Reprinted from *The Medical News*.

Bureau of Information.

Questions on all subjects relating to medicine will be received, assigned to the member of our staff best capable of advising in each case, and answered by mail.

When desired, the letters will be printed in the next issue of the Journal, and advice from our readers requested. The privileges of this Bureau are necessarily limited to our subscribers. Address all queries to

Bureau of Information.

TIMES AND REGISTER,

1725 ARCH STREET,

Philadelphia, Pa.

ABSCESS OF LUNG.

MR. T., aet 44, farmer, an inveterate smoker, has exposed himself to all kinds of weather. His present illness began similar to an attack of pneumonia. Had chill followed by rise of temperature, ranging from 102° to 104°; some pain at apex of right lung; expectorating thin frothy mucus. The third day of his illness his temperature became normal, appetite returned, all symptoms seemed favorable. He remained in this condition thirty-six hours. He awoke the fifth morning of his illness coughing and strangling; he commenced to expectorate large quantities of a thin yellowish pus, which had the scent and appearance of a decayed egg. The sputa has since changed, is thicker and does not smell so much. His cough is now spasmodic. He says the sputa burns and irritates throat and mouth. At present patient is hopeful, has good appetite, bowels regular. There is a slight dullness just below right nipple of the right lung, space about two inches square, white at apex. I think there is a cavity about size of hen's egg. His temperature is normal; circulation, 75; full open pulse; fourth week of sickness.

[Undoubtedly abscess of lung tissue; whether caused by embolism or inflammatory condition would be an open question. The primary chills and fever may be the commencement of suppurative process. Look for heart lesions; if not found ascertain if there be tubercular process by microscopic examination of sputa. Treat with salicylates and plenty of good nutrition and tonics.

—ED. T & R.]

ENDOMETRITIS.

MRS. W., has been married seven years, no children. A few months after marriage commenced to suffer with dysmenorrhea. Her general health is fair, good appetite all the time. Menses come on every twenty-one to twenty-four days and lasts about one and a half to two days. The first day she suffers so much that she has to have an opiate. She occasionally suffers with leucorrhea. Have used innumerable remedies, but with very little benefit. The case puzzles me. There is no malposition of womb or any wrong there that is sufficient to cause such trouble.

WATER VALLEY, KY.

[This is probably a result of endometritis, possibly of gonorrheal origin. Inject a solution of eugenol and aristol in vaseline oil. If os is too narrow dilate under an anesthetic.—Ed. T. & R.]

THROUGH the TIMES AND REGISTER I have become almost acquainted with you. I notice that you have a sanatorium for nervous diseases. I now desire to consult you about my wife who has been confined two weeks ago tonight. For months previous to confinement she had an awful dread or horror of confinement and could not sleep. I gave her sulfonal, coloramid and hyoscyamus, and managed her well up to confinement and pushed nutrition regularly.

Now the great trouble is she cannot sleep and is very nervous and anemic. Her mind is so bent on the sleep question that nothing will persuade her that sleep can ever return without hypnotics. I have been diminishing the dose and passing off a placebo for the medicine, but it was no use. Neurasthenia or want of nerve force is troubling her, associated with anemia and some pain in the top of the head, which I suspected as clavus. I have used sodii bromidi nux vomica, quinine, iron, strychnine—what would you advise me to do toward procuring sleep. Would bathing at night and galvanism be any use to arouse the nerve force? And do you think sulfonal is harmless or does it tend to increase sleeplessness and along with it anemia, etc.? The sulfonal I noticed gave the urine a peculiar reddish brown color. What she needs most now is building up and strengthening of her

nervous system and blood and natural refreshing sleep. I shall be greatly obliged if you will give me some definite advice or suggestions in her case, as I have for the last six months been greatly worried about her.

R. M.

STANLEY BRIDGE, P. E. I.

[Good nutrition, strong nerve tonics, such as Wampole's or Fellow's, bathing at night with warm water followed by rubbing with a friction towel. Do not use hypnotics to any great extent. Restore strength; plenty of open air exercise.

Ed. T. & R.]

I HAVE a case of epilepsy in a man 39 years old, that dates from an attack of scarlatina when he was but two years of age. Does not have an aura; spasms come on weekly, aggravated by smoking, but does not see any ill effects from chewing. What would you suggest as dosimetric treatment? I see nothing in your "Manual" to meet the case. If dosimetry is of any value I want to make a good stroke in this case. Am inclined to use valerianate of strychnia. But shall be pleased to have your advice.

LUTHER KEMPTNER,

UNIONTOWN, MD.

[Bromides of gold, nickel, arsenic and iron may be used successively in connection with full doses of Bromide of potassium. When the successful point has been reached the doses may be reduced. The inquirer is referred to Dr. Waugh's "Manual of Dosimetric Practice" for further light on the treatment of epilepsy.—Ed. T. & R.]

REFERRING to your notice of last issue I inclose \$1.00 availing myself of your offer of REGISTER to January 1895. Please publish the cost of brucine granules 1-36 to 1-12, also glycozone, etc. I think it would be well to publish the Dosimetric medicines in TIMES AND REGISTER giving prices, etc., to keep us refreshed.

R. MAC NEILL, M. D.

STANLEY BRIDGE, P. E. ISLAND.

[Brucine granules are quoted by the Philadelphia Granule Co., at 35 cents per 100; \$1.50 per 500; and \$2.50 per 1000, for gr. 1-30; and special sizes at rates as agreed according to formula. Glycozone is made by Marchand. We cannot give prices, as different makers vary, and the journal does not favor any single firm. But it would be a good thing for their advertisements, as many would prefer solid information as to prices, rather than testimonials.—W. F. W.]

WILL you please describe the best way of giving and the indications for giving the cold pack.

What is the significance of pain at the lower end of the sternum so often complained of by people who otherwise seem to be in good health? a reply through the TIMES AND REGISTER will greatly oblige

D. J. TILLOTSON, M.D.

[Cold is an application which may be used to reduce any fever that has reached 103° F. or over. It is generally applied in typhoid fever and pneumonias. The usual method of procedure, however, is by the cold bath. Water gradually cooled down from 90° F. to 60° F. while the patient is submerged. Occasionally the wet sheet is employed, in which a patient is wrapped with a blanket placed about him, and the sheet. Heat may also be abstracted by means of bottles filled with ice cold water placed about the patient. Probably the most acceptable method of applying cold for high fevers is the wet sheet as described above.]

Pain at the lower end of the sternum is a vague symptom and may accompany a number of disorders.

1st. Gastralgia, acute or chronic or neuralgia may be indicated by pain in the region above mentioned.

2d. Mediastinal tumors, cancer of stomach, gastric ulcer, chronic dyspepsia and such diseases may cause pain in that region.

3d. Occasionally diseases of the heart may have pain referred to the sternal region.—Ed. T. & R.]

I HAVE a patient, a nephew, who is in a very bad condition from rheumatism. If you can give me any help or advise any treatment that will give him relief I will feel under many obligations to you. Patient is about 50 years of age, a farmer, weight about 150 to 160 lbs. General health previously good, never had any serious illness; of good healthy parentage. He has had slight attacks of rheumatism in his knees, fingers and wrists, but never has taken treatment for it. Has been gaining all the while. Last April his attack was more violent, during which he was treated by two physicians, and growing worse. He has been bed-ridden since last August; cannot walk or help himself any. I was called to see him the first of October last; his knees, wrist, and fingers were swollen and very painful; his general health bad; appetite poor, bowels constipated; urination difficult. These conditions improved under my treatment, and the secretions are all acting well; has better use of his limbs but he is still bed-

ridden, and suffers pain and soreness more or less every three or four days, then seems better for the same length of time.

I have tried the usual remedies, salicylic acid, iodide of potassium, cimicifuga, gelsemium, guaiacum, nitrate of potassium, sulphur, have given steam baths every night, well rubbed twice a day with stimulating liniment, and diseased parts well wrapped with flannels.

I have been practising medicine for forty years in the rural districts of Lincoln County, N. C., and have never had a case of rheumatism but I managed to get up until this one.

DR. W. A. THOMPSON,

Hall's Cross Roads, Lincoln Co., N. C.

[It looks as if the doctor had more than rheumatism to deal with in this case. Suppose, doctor, you examine the heart for valvular lesions so common in rheumatism; also determine very carefully whether the swellings of the joints be inflammatory in nature or effusions. Use iodide of strontium inunctions in hot lard twice a day. Place him on tonics, good diet and if not successful get him into a different locality where the atmosphere is high and dry.—Ed. T. & R.]

THE CARE OF THE EYES.

To the student and teacher, the eyes are so important that they should receive the greatest care, and yet, although the eyes are almost always good before children attend school, we find that a larger and larger per cent. of pupils have imperfect eyes (as we advance from the kindergarten to the high school,) until, it is said, that among educated Germans no less than 67 per cent. have imperfect or defective eyesight. *It is certain that these imperfections in great measure, develop during the years of school life.* If this is so, how are these imperfections caused?

1. By using the eyes too constantly at a short distance, as in reading and writing. Indian boys in the woods never become nearsighted; but thousands of school children do every year.

2. By using the eyes too constantly and too long at a time.

3. By using them when weak from sickness. After the diseases of childhood, as measles, scarlet fever, whooping cough, etc.

4. By using the eyes in 'insufficient light. Very many of our school rooms

are poorly lighted. Children cannot see in them on dark days. Rooms are made still darker by the use of curtains and blinds which are often partly closed or drawn and are placed at the top instead of at the bottom of the windows. Windows are very often too small. They are often filled with flowers. If children study in the evening it is too often with a poor light.

5. The print of school books is often too small and indistinct. The use of maps with many names upon them is especially trying to children and injurious to the eyes.

6. Blindness is now known to be due in the very many cases (setting aside accidents) to an inflammation of the eye in early infancy.

RULES FOR THE CARE OF THE EYES.

1. Always have an abundance of good, steady light for any work which you may have on hand. Do not work in a poor light.

2. Avoid a glaring light. Do not allow the direct sunlight to fall directly upon a book you are reading, or upon any work you are doing.

3. Let the light come from one side, behind or above, but not from in front.

4. Never read or use the eyes closely during twilight. Put up your book when the sun goes down. Do not sew on black goods at night. Do not work with the microscope at night.

5. Never use a flickering light when reading or writing.

6. Avoid suddenly passing from the shade into a bright and glaring light.

7. When using artificial light, if the eyes are weak, it is always beneficial to wear a shade *over* the eyes, which will cut off all direct light from them; the desk or table should be covered with a light blue paper or cloth. Colored shades on lamps are better than those of pure white.

8. Use a lamp with a good, large burner, the best oil, and try to obtain as white light as possible. A good lamp is worth all it costs.

9. Hold the head erect; and at such a distance from the lamp that it will not be heated by it. When the head and eyes are hot, bathe with pure cold water. Do not bend over your work.

10. Whenever the eyes pain on using or are fatigued, or the images are blurred, stop using them. Look up and away from the work frequently, and in bad cases study only by daylight, or not at all for a week or more.

11. Do not confine the eyes to work too closely. Hold the book at least 12 inches from the eyes; this will prevent growing nearsightedness.

12. Avoid books poorly printed, with small type, and on poor paper. Use black ink, never that which is pale. Keep the slate clean.

13. Avoid using the eyes for reading when riding in the cars, in a carriage, or when walking, etc.

14. Never read when lying down.

15. Do not read much during convalescence from any debilitating disease.

16. As a rule, do not read or study on an empty stomach. Drink a glass of milk, or eat a cracker before beginning the day's work. Do not use the eyes when sleepy. Do not try to study when the head aches.

17. Keep all patented eye-washes out of the eyes, and avoid all quack eye-doctors. The eye is too precious an organ to be trifled with.

18. Keep all soap out of the eyes; be especially careful of children in this respect.

19. When the eyes are inflamed, sleep much and thus restore them.

20. In all cases of weak-sight, near-sight and far-sight, squinting or cross-eye have the eyes carefully examined by a competent oculist, and follow his advice implicitly. An ordinary jeweler or travelling spectacle vendor is not the person of whom we should buy glasses for our eyes. When glasses are prescribed, procure and wear them. It is the height of folly not to wear glasses when they are needed.

21. *Avoid colored glasses and goggles*, unless prescribed by a physician competent to judge of your condition.

22. Have all diseases of the eye treated early and skillfully, and remember that the well eye sympathizes with the diseased one, and you may lose both unless early attention is given the matter. Diseases of the eyes in which a large amount of matter forms are often very contagious, and patients so affected should be care-

ful to get no matter from the diseased eye into the well one, and persons so afflicted should have a separate basin and towels for washing purposes.

23. Arrange your bed so that the morning light will not fall into the eyes. This is often trying and injurious to them. Sleep in a darkened room, and never keep a lamp burning while you sleep.

Foreign Particles in the Eye.—Never needlessly expose the eyes to foreign particles, but when necessary, wear plain glasses or goggles. When experimenting with chemicals, always turn the mouth of the tube or bottle away from the face and eyes. Whenever an eye is injured severely, place the patient immediately in a dark room, and under the care of a skilled physician, whose directions must be implicitly followed. The foreign bodies may be solids, as sand, cinders, hair, dirt, etc., lime, acids, or alkalis. Don't rub the eyes, avoid sudden glares of light; never look directly at the sun.

Treatment.—To remove the solid particles from under the lids—From the lower lid, it is sufficient to pull the lid away from the eye, and to wipe the body with a piece of moist paper or the corner of a handkerchief; if it is under the upper lid, grasp the lid firmly between the thumb and finger, lift it from the eyeball, and draw it down over the lower lid, and then allow it to slide slowly back to its natural position. The foreign body will be scraped off on the lashes. The operation may be repeated several times. Or, lift the lid from the eyeball, allow the tears to accumulate beneath the lid, and forcibly blow the nose. Or, place in the eye a few grains of flaxseed, which forming a mucilage will probably bring relief. Or, place across the upper lid the point of a pencil or bodkin, and turn the lid back over it; in this way the foreign particle is brought into distinct view and can be readily wiped away.

2. Lime and Roman cement are very destructive to the eyes if permitted to remain any considerable time. Wash the eyes immediately with water, then with water containing vinegar or lemon juice.

3. For acids in the eye, wash with water containing a little ammonia or baking soda.

4. For alkalis, wash with water containing vinegar or lemon juice.

Wounds of the Eyes.—When an eye has been wounded in any manner, a handkerchief should be placed over it at once, and the person should lie down on his back immediately, and thus remain quietly until examined by the most skilled physician who can be secured. The reason for these directions is this: A wound of the eye may permit the escape of the lenses, and a consequent loss of sight. Following the directions laid down may save the eye and prevent blindness.

Rules of State Board of Health.

The Medical Digest.

MEDICINE.

Treatment of Phlyctenular Ophthalmia.—This very common complaint, and in some cases very obstinate to treatment has proved so amenable in my hands that I feel that I should give the profession the benefit of my experience, although at the same time I claim no originality for the method which I have used; but as I have seen some instances in which other physicians had pronounced the case incurable, and have seen the symptoms vanish so quickly under the proper treatment, I feel that those members of the profession who have never tried this treatment, should try it and thus save a vast amount of annoyance, to say the least.

As it is well known this disease is found most often in scrofulous children. The eye is very deeply injected, the lids are edematous, and in some cases it is almost impossible to open the lids, so great is the swelling. The child seeks to shield the eye from the effect of the light and consequently seeks dark corners or buries its face in its hands, sometimes when the photophobia is very bad the child screams when carried into the light.

When the eye is examined we find one or more ulcers on the margin of the cornea, sometimes there are several, but in my experience there is generally from one to three. Having briefly outlined the symptoms, I will state what, in my

hands, has proved the most effective treatment, but as I said before this treatment is not original with me, and I do not now recall who was the first to use it.

When I first see a patient with the above symptoms I immediately give:

R Hydrarg. oxidi flav gr. ij
Adipis 3 iv
M. et ft. unguent.

Sig: Put a piece of the ointment about half the size of a split pea under the under the upper lid of the affected eye twice a day.

I prefer lard in the above prescription to vaseline, and I think that those who use the two will agree with me. To those physicians who compound their own medicines, I would suggest that they thoroughly pulverize the yellow oxide of mercury, for if there are any small lumps of the medicine incorporated with the lard, it gives unnecessary pain to the inflamed eyes, and besides might prove hurtful.

With the above you may also give constitutional treatment, such as the syrup of the iodide of iron, cod liver oil or whatever may seem expedient, and I think it advisable to give some such treatment to avoid a recurrence of the trouble. If any of my brother "Country doctors" have a case of this trouble on hand and have tried other remedies, they may save sending their patient to the city oculist, and may also increase their reputation as an eye doctor by trying this treatment.

—*Dr. Bowling in St. Louis Clinique.*

THERAPEUTICS.

Tropacocaine in Ophthalmic Practice.

—George Ferdinands, of Aberdeen, after a series of experiments during a period of six months, has arrived at the following conclusions:

1. Tropacocaine is more reliable and deeper in its action than cocaine, and the anesthesia it produces lasts a little longer. Unlike cocaine, it anesthetizes inflamed tissue—at least, more deeply than does that salt. There is complete absence of the haze over the cornea which is so characteristic of cocaine anesthesia. This was specially appreciated when needling. The strength of the solution depends on the requirement. For general use 2 or 3

per cent. is sufficient, and a 5 per cent. solution may be used with safety when anesthesia of the deep-seated parts is required.

2. Solutions of tropacocaine made with distilled water keep well and retain their strength for months. One solution (3-per-cent.) prepared in January last, although now a little cloudy, has not lost its activity. So far, no fungus has been noticed growing in the solutions.

3. With the exception of one case, in which the 10-per-cent. solution was used, tropacocaine gave rise to no disagreeable symptoms. It practically has no mydriatic action; neither is it hemostatic. But it certainly did not give rise to "intense hemorrhage," as was the experience of Seifert (*Internat. klin. Rundschau*, No. 8, 1893).

The author is inclined to think that cocaine will eventually be replaced by tropacocaine when its advantages are fully understood. Even if it were only for its antiseptic properties, the new anesthetic should be given the preference. The price is not prohibitive and increased demand will place it within the reach of all.—*Med. Bulletin.*

CHILDREN'S DISEASES.

A Second Attack of Measles.—At a meeting of the Society of Practical Medicine and Surgery, M. Diamantberger reported the case of a child, two and a half years of age, in whom a second attack of measles occurred after an interval of six months. The recurrent disease was accompanied by a severe broncho-pneumonia and terminated in death. The different etiological details of this case suggested to the speaker an additional prophylactic precaution, viz., that every patient, although he may have had measles, should be removed from contaminated surroundings if he is suffering from any inflammatory condition of the air-passages, as simple or tuberculous bronchitis, broncho-pneumonia, pneumonia, and even from a pharyngeal, laryngeal, or naso-buccal affection.

—*Le Progres Medical.*

Send One Dollar for the TIMES AND REGISTER for one year.

Prescriptions

PILOCARPINE IN DIPHTHERIA.

Hirschfield claims excellent results from the use of pilocarpine. For a child of six years he prescribes as follows :

R Pilocarpin gr. $\frac{1}{2}$
 Spt. vini gal f $\frac{3}{4}$ iv
 Syr. aurant f $\frac{3}{4}$ i
 Aquæ q. s. ad f $\frac{3}{4}$ iij M
 Sig.—One teaspoonful every two hours.

—*Am. Med. Gazette.*

FOR HERPES ZOSTER.

Brocq recommends the following ointment :

R Boric acid 1 part
 Oxide of zinc
 Starch aa 2 parts
 Vaseline 6 parts
 Lanoline 9 parts

The vesicles are carefully opened by means of a needle sterilized in the flame of an alcohol lamp, and are then washed with a boric acid solution containing a small proportion of alcohol. After this they are covered evenly with the above paste, and powdered with starch, and over all is placed a thick layer of wadding. If the pain is very severe, a little chlorohydrate of morphine or cocaine is incorporated with the ointment.

—*N. Y. Med. Record.*

GONORRHEA.

In any stage, try internally :

R Potassii bromidi $\frac{3}{4}$ iv
 Sodii bicarbonatis $\frac{3}{4}$ j
 Tinct. cannabis indicæ f $\frac{3}{4}$ iv
 Spts. eth. nitrosi f $\frac{3}{4}$ iij
 Aquæ ad f $\frac{3}{4}$ vj
 M. ft. sol. Sig. One drachm three times a day.

And as an injection :

R Extract Pinus Canadensis (white) $\frac{3}{4}$ ij
 Tinct. Opii f $\frac{3}{4}$ jss
 Glycerini f $\frac{3}{4}$ jss
 Aquæ Rosæ, ad f $\frac{3}{4}$ vj
 M. Sig. Inject every three hours.

FOR SORE NIPPLES

R Ichthyol Drachm 1
 Lanoline " 1 $\frac{1}{2}$
 Glycerine " 1 $\frac{1}{2}$
 Olive oil " 2 $\frac{1}{2}$
 M. Sig. Apply. Wash off before nursing.
 —*Med. Record*

GASTRIC TROUBLE IN NEURASTHENIC PATIENTS.

R Phosphate of zinc ii grs.;
 Bromide of zinc xx grs.;
 Bromohydrate of quinine xxx grs.;
 Ext. of nux vomica iii grs.
 M. S. Divide into 30 pills. Three daily.

—*Med. Press and Circular.*

Note.

Dr. A. Lagorio, Director of the Chicago Pasteur Institute, gives the results of the preventive inoculations against hydrophobia attained at this Institute since its inauguration, July 2d; 1890. to date, as follows :—302 persons have been treated, classified as follows :

104 bitten by animals recognized and ascertained to be rabid by the experimental proof made in the laboratory ; or by the death of other persons or animals bitten by the same animal.

126 bitten by animals recognized to be rabid by the symptoms of the disease shown during life.

72 bitten by animals strongly suspected to be rabid.

282 persons were bitten by dogs, 7 by horses; 7 by cats; 3 by skunks; 2 by wolves; 1 by a mule.

The persons treated came from the following States: 185 from Illinois; 32 from Iowa; 23 from Indiana; 21 from Kansas; 9 from Ohio; 5 from Missouri; 5 from Arizona; 4 from Minnesota; 4 from Michigan; 4 from Louisiana; 3 from Tennessee; 3 from Kentucky; 2 from Texas; 1 from Wisconsin; 1 from South Dakota.

One death was reported among the patients treated, thus giving a mortality of only 0.33 per cent.

A RECEPTION TO DR. HOLMES.—The College Club of Boston gave a reception to Dr. Oliver Wendell Holmes Saturday afternoon, Nov. 25. About five hundred persons were presented to Dr. Holmes, who received them seated in a laurel-decorated chair in the parlor, under a bower of palms. During the evening Dr. Holmes recited "The Last Leaf," "Dorothy Q." and "The Chambered Nautilus."